Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $619.00 for dates of service 05/03/01 through 07/06/01.

   b. The request was received on 02/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA(s)
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/19/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 06/21/02. The response from the insurance carrier was received in the Division on 06/27/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   The Provider did not submit a Letter Requesting Dispute Resolution.

2. Respondent:

> "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Acts and Rules.
>
> (Claimant) sustained a cervical strain and head contusion on ___ while employed as a processor by… (She) began treatment at (facility) on 4/30/01, and had been seen 43 times by (Provider) from 04/30/01 to 7/27/01. He billed for 43 units of 99213 (an Evaluation & Management code) which did not include the 4 ROM (95851) services or 1 MT (97750-MT) in dispute. This is an excessive amount of evaluation and management. A careful review of the criteria established by TWCC and the CPT Code Book shows that a thorough hands-on physical examination to include all body systems is an essential component of an E&M code. In addition to this service, this provider performed a ROM examination on 4 separate occasions and a Muscle Test on one. There is no clinical necessity for quantitative measurements of this sort except as a component of a Functional Capacity Examination. Performed in this manner they serve only a documentary purpose rather than for any medical necessity. These tests did not alter the patient's treatment plan nor contribute to her early recovery."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date (s) of service eligible for review are those commencing on 05/03/01 and extending through 07/06/01.

2. The denials listed on the EOBs are "G-INCLUDED IN GLOBAL. D-DUPLICATE CHARGE."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
05/03/01 05/17/01 06/05/01 07/06/01 	95851 95851 95851 95851 	$36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00 $36.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	G G G G G G G G G G G G G G G G G	$36.00	MFG E/M (IV)(A)(1) CPT descriptor	The Carrier denied the charges as G-Global. In their position statement the Carrier raises the issue that CPT code 95851 is global to 99213, and is excessive in it's use. The MFG does not state any where, except when the ROM is rendered by a physical or occupational therapist, that CPT code 95851 is global to 99213. According to the referenced Rule: "When the doctor performs a complete diagnostic service during an office visit (e.g, technical and professional component of a study), both components of the service shall be reimbursed in addition to the office visit." The documentation indicates that the services were rendered. Therefore, reimbursement is recommended in the amount of **$576.00**. **(36x16=$576.00)**
05/04/01	97750-MT	$43.00	$0.00	D	$43.00 (per body area)	MFG MGR (I)(3)	The Carrier denied CPT code 97750-MT as "D- Duplicate charge." The EOBs submitted in the Provider's dispute packet indicate that CPT code 97750-MT has not been paid. The Carrier has not submitted any evidence to support that these charges had been paid. Medical documentation indicates that the services were rendered. Therefore, reimbursement is recommended in the amount of **$43.00**.
Totals		$619.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$619.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $619.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 27th day of September 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb